RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-030917

STATE FILE NUMBER

FILED VS AUG 17 1960 Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 387

NDED

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: INDEPENDENCE
Length of stay in 1b: 43 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: INDEP. SAN. & HOSP.
Inside Limits: Yes XX No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: JACKSON
c. CITY OR TOWN: INDEPENDENCE
Inside Limits: Yes XX No ☐
d. STREET ADDRESS (If outside, give location): 615 Lakeview
Reside on Farm: Yes ☐ No XX

3. NAME OF DECEASED (Type or print): First: Dozier Middle: Kelley Last: Sellers

4. DATE OF DEATH: Month: Aug. Day: 11 Year: 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. Married XX Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 8-24-1884

9. AGE (last birthday): 75
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HR: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FARMER

10b. KIND OF BUSINESS OR INDUSTRY: FARMING

11. BIRTHPLACE (City and state or country): MCKENZIE, ALLABAMA

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: JOHN D. SELLERS

13b. MOTHER'S MAIDEN NAME: HARRIETT V. STEWARD

14. NAME OF HUSBAND OR WIFE: LILLIE SELLERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 495-24-4288

17. INFORMANT Address: Lillie Sellers, 615 Lakeview, Indep., Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis – — INTERVAL BETWEEN ONSET AND DEATH: 2 days.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): generalized Arterio-sclerosis — 2 years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Aug. 9, 1960 to Aug. 11, 1960 and last saw him alive on Aug. 11, 1960
Death occurred at 6½ P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Fred W. Hinch, M.D.

22b. ADDRESS: 10229 Indep. Ave. K.C. Mo.

22c. DATE SIGNED: 8/11/60.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: 8-13-60

23c. NAME OF CEMETERY OR CREMATORY: MOUND GROVE CEMETERY

23d. LOCATION (City, town, or county) (State): INDEPENDENCE, MISSOURI

24. FUNERAL DIRECTOR ADDRESS: GEO. C. CARSON & SONS, INDEPENDENCE, MO.

25. DATE RECD. BY LOCAL REG.: 8-12-60

26. REGISTRAR'S SIGNATURE: James L. Craig

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

AUG 23 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Dean W. Huff

Licensed Embalmer No. 4914

P. O. Address Indep, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to c with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.